APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT DECIDED AND FILED APRIL 5, 2004

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 02-3645

COB CLEARINGHOUSE CORPORATION,
also known as Digital Healthcare, Inc.,

Plaintiff-Appellant,

v.

AETNA U.S. HEALTHCARE, INC.; GREAT WEST LIFE AND ANNUITY INSURANCE CO.; BLUE CROSS & BLUE SHIELD OF KANSAS CITY; CONNECTICUT GENERAL LIFE INSURANCE COMPANY,

Defendants-Appellees.

Appeal from the United States District Court for the
Northern District of Ohio at Cleveland
No. 02-00020—Patricia A. Gaughan, District Judge.

Argued: December 12, 2003.

Decided and Filed: April 5, 2004.

Appendix A

Before SILER and COOK, Circuit Judges;
BERTELSMAN, District Judge.*

OPINION

COOK, Circuit Judge. Plaintiff-Appellant, COB Clearinghouse Corp. (COB), appeals the district court's dismissal of its claims against Aetna U.S. Healthcare, Inc., Great West Life and Annuity Insurance Company, Blue Cross and Blue Shield of Kansas City, and Connecticut General Life Insurance Co. (collectively the Insurers). We affirm.

I. BACKGROUND

A. Procedure

COB filed a Complaint against the Insurers, alleging that it was an authorized agent of Goodyear Tire & Rubber (Goodyear), Bridgestone-Firestone, Inc. (Bridgestone), Babcock & Wilcox, Progressive Processing, Inc. (Progressive), FirstMerit Bank (FirstMerit), Cambridge Industries, Inc. (Cambridge), and State Industries, Inc. (State) (collectively the Employers). The Employers provide ERISA-regulated health care benefits plans to their employees and their employees' dependents. COB claimed that it represented the interests of the Employers pursuant to contracts it had entered into with each Employer.

The Insurers, on the other hand, contracted with different employers to provide similar health care benefits through non-ERISA health insurance policies.

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* The Honorable William O. Bertelsman, United States District Judge for the Eastern District of Kentucky, sitting by designation.

Appendix A

The Complaint set forth five claims. Count One alleged a violation of the Employee Retirement Income Security Act ("ERISA"), and Count Two alleged "federal common law claims." Counts Three through Five alleged claims for unfair and deceptive insurance practices, bad faith, and unjust enrichment.

The Insurers[1] filed Motions to Dismiss the Complaint pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6), arguing that COB lacked standing to bring the claims and failed to state a claim upon which relief could be granted. The district court agreed, finding that COB had no standing to bring Counts One and Two and, therefore, the district court had no subject matter jurisdiction over the case.[2] Counts Three through Five were dismissed as state law claims which were preempted by ERISA. COB has appealed only the district court's dismissal of Counts One and Two.

B. Coordination of Benefits Issues

COB's Complaint raised allegations relating to "coordination of benefits" issues. The necessity for health

1. Aetna filed a Motion to Dismiss, in which Connecticut General and Great-West joined. Upon disposition, the district court also granted a dismissal, sua sponte, to Blue Cross & Blue Shield.

2. The district court also found that Counts One and Two failed to state a claim upon which relief could be granted. COB alleged several errors challenging that determination, and the Insurers alleged an alternative argument for affirming the district court's decision. Due to our disposition of the issue of COB's standing, it is not necessary for us to address these other issues.

insurers to coordinate health benefits arises when two (or more) health care plans provide benefits to the same individual. The insurers must then determine who is primarily and who is secondarily liable for the payment of that individual's health care benefits. This determination can sometimes be made by reviewing the provisions of the individual insurance contracts. In some instances, however, the insurance contracts may conflict. For example, each may state that it provides only secondary coverage under the circumstances. *See McGurl v. Trucking Employees of North Jersey Welfare Fund, Inc.*, 124 F.3d 471, 473 (3d Cir.1997). Many states, including Ohio,[3] have resolved these conflicts by adopting part or all of the Model Regulations set forth by the National Association of Insurance Commissioners (NAIC), an independent group of state insurance regulatory commissioners. *See McGurl*, 124 F.3d at 483.[4] That state law would apply in cases where coordination of benefits is required between two plans which are not subject to ERISA.

ERISA, however, provides no guidance on coordination of benefits issues. *See Regents of the Univ. of Mich. v. Employees of Agency Rent-A-Car Hosp. Assoc.*, 122 F.3d 336, 339 (6th Cir.1997). In cases involving two ERISA-regulated plans, therefore, federal courts have fashioned federal common law to resolve these issues. *McGurl*, 124 F.3d at 484 (adopting "employer first" rule, providing that plan

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3. *See* Ohio Administrative Code § 3901-1-56(G).

4. In some cases, the insurance policy at issue may also incorporate the provisions of the NAIC Model Regulations. *See Baptist Mem'l Hosp. v. Pan American Life Ins. Co.*, 45 F.3d 992, 995 (6th Cir.1995).

which covers beneficiary as employee is primary and plan which covers beneficiary as dependent of employee is secondary). *See also PM Group Life Ins. Co. v. Western Growers Assur. Trust*, 953 F.2d 543, 548 (9th Cir.1992); *Reinforcing Iron Workers v. Mich. Bell Tel. Co.*, 746 F.Supp. 668, 670-71 (E.D.Mich.1990) (adopting the "birthday rule," declaring plan of employee whose birthday occurs earlier in the year primarily responsible for medical benefits of a minor, where parents are both covered by separate ERISA plans).

COB alleged that, in this case, certain beneficiaries were insured both under one of the Employers' self-funded ERISA plans and under one of the Insurers' non-ERISA policies. COB claimed that the Insurers' policies were primary, presumably because the coordination of benefits clauses of the applicable insurance contracts conflicted. COB then argued that the district court should extend the federal common law established in *McGurl* to these cases that involve only one ERISA-regulated plan. Under such a rule, COB contends that the Employers paid claims for which the Insurers were primarily liable and they were only secondarily liable.

C. COB's Contracts with the Employers

COB bases its claim to being an authorized agent of the Employers upon the contract—called either the "Audit Agreement" or the "Recovery Service Agreement"—that it entered into with each Employer. While the contracts with the seven Employers were each slightly different, the agreements generally provided that COB would review each Employer's records, use its "proprietary systems"

to determine if the Employer made payments under its health care plan for which the Employer was only secondarily liable, and attempt to collect payment from the party that COB believed to be primarily liable in exchange for a percentage of the amounts recovered.

The relevant provisions of the Goodyear, Bridgestone, Progressive, Babcock & Wilcox, and FirstMerit agreements were substantively identical. Each of these five agreements contained an "agency clause," appointing COB its agent for certain purposes:

> [Employer will] make [COB,] and its contractors, [the Employer's] agents for the purpose of carrying out an audit of coordination of benefits issues, and the subrogation and collection of indemnities due as a result of such audit as provided for and privileged by standard rules [or law] (for example, Section 3902.13(F) of the Ohio Revised Code or the rule[s] of the [NAIC], as interpreted by the state at issue on any given claim).

Those agreements then required COB to make three attempts to collect every claim and "further pursue every claim of a value exceeding $500.00 for the period of at least one year, or until collection of the correct indemnity, or settlement of the claim, whichever occurs first." The agreements all provided, however, that COB would "commence no litigation in the name of [the Employer], or on its behalf, without prior notice to [the Employer]."

The other two agreements were similar. The State agreement differed in that it authorized COB to report potential claims to State, but did not authorize COB to pursue them. The Cambridge agreement differed in that it authorized COB to "conduct litigation to recover amounts owed" without requiring prior notice to Cambridge.

II. ANALYSIS

The district court dismissed those counts COB appeals—Counts One and Two of COB's Complaint—on the ground that COB did not have standing to bring the case. "We review a district court's decision to grant a motion to dismiss for lack of subject matter jurisdiction *de novo.*" *Joelson v. United States*, 86 F.3d 1413, 1416 (6th Cir.1996). "For purposes of ruling on a motion to dismiss for want of standing, both the trial and reviewing courts must accept as true all material allegations of the complaint, and must construe the complaint in favor of the complaining party." *Warth v. Seldin*, 422 U.S. 490, 501 (1975). Having invoked the jurisdiction of the federal courts, however, it is the plaintiff's burden to demonstrate that jurisdiction is proper. *See Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561 (1992); *Kardules v. City of Columbus*, 95 F.3d 1335, 1346 (6th Cir.1996).

Assuming, as we must, that COB was an authorized agent of the Employers under the terms of the parties' agreements, we must determine whether such an authorized agent has standing under ERISA to pursue these claims.

Appendix A

ERISA strictly limits standing. 29 U.S.C. § 1132(a)(3)[5] provides, in pertinent part, that:

> A civil action may be brought –
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> . . .
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan. . . .

And courts narrowly construe ERISA to permit only the parties specifically enumerated to bring suit. *See Simon v. Value Behavioral Health, Inc.*, 208 F.3d 1073, 1081 (9th Cir.2000) (citing *Franchise Tax Bd. v. Constr. Laborers*

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5. COB did not identify the ERISA provision under which it brought its Complaint. The district court, however, broadly interpreted the Complaint and assumed that the action was brought pursuant to 29 U.S.C. § 1132(a)(3), which was the provision identified by COB in its brief in opposition to the Motion to Dismiss. There was some dispute before the district court regarding whether COB sought equitable relief or monetary damages. We note that 29 U.S.C. § 1132(a)(3), which provides for equitable relief, allows "participants, beneficiaries, and fiduciaries" to bring claims, while 29 U.S.C. § 1132(a)(1), which provides for monetary damages, only allows "participants and beneficiaries" to file suit. Like the district court, we will assume that COB brought the action pursuant to 29 U.S.C. § 1132(a)(3), as that is the only section which gives rise to any argument that COB has standing in this case.

Vacation Trust for S. Cal., 463 U.S. 1, 27 (1983)). *See also Teagardener v. Republic-Franklin Inc. Pension Plan*, 909 F.2d 947, 951 (6th Cir.1990) (narrowly construing proper parties under 29 U.S.C. § 1132(a)(1)). Indeed, even an assignee of a participant, beneficiary, or fiduciary is generally not permitted to maintain an ERISA claim. *See Simon v. Belwith Int'l, Inc.*, 3 Fed. Appx. 363, 364 (6th Cir.2001). It is undisputed that COB was neither a participant, a beneficiary, nor a fiduciary according to the dictates of the statute. COB argues, nevertheless, that the Employers whom it represented were fiduciaries and that as the agent of the Employers, it could bring suit.

Whether an employer who is also an ERISA plan sponsor is a fiduciary of the plan generally requires a detailed analysis of the employer's actions and whether those actions were performed in the employer's fiduciary capacity. *See Hunter v. Caliber Sys., Inc.*, 220 F.3d 702, 718 (6th Cir.2000). "[W]e must examine the conduct at issue to determine whether it constitutes 'management' or 'administration' of the plan, giving rise to fiduciary concerns, or merely a business decision that has an effect on an ERISA plan not subject to fiduciary duties." *Id.* (citations and internal quotations omitted). But even assuming that the Employers were fiduciaries who had a right to file suit pursuant to 29 U.S.C. § 1132(a)(3), that assumption does not confer standing on COB to sue in its own name as the Employers' agent. Restatement (Second) of Agency § 372(2) (1958) provides that "an agent does not have such an interest in a contract as to entitle him to maintain an action at law upon it in his own name merely because he is entitled to a portion of the proceeds as compensation for making it or because he is liable for its breach."

Appendix A

III. CONCLUSION

Given COB's lack of standing, we affirm the decision of the district court.

APPENDIX B — MEMORANDUM OF OPINION AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OHIO, EASTERN DIVISION FILED MAY 3, 2002

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

CASE NO. 1:02 CV 20

JUDGE PATRICIA A. GAUGHAN

COB Clearinghouse Corporation,

Plaintiff,

vs.

Aetna U.S. Healthcare, Inc. et al.,

Defendants.

MEMORANDUM OF OPINION AND ORDER

Introduction

This matter is before the Court upon defendant Aetna U.S. Healthcare, Inc.'s Motion to Dismiss (Doc. 10), defendant Connecticut General Life Insurance Company's[1]

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1. Connecticut General Life Insurance Company was substituted as the proper party in place of CIGNA Corporation which was named in plaintiff's Complaint.

Motion to Dismiss (Doc. 36) and defendant Great-West Life and Annuity Insurance Company's Motion to Dismiss (Doc. 38). For the following reasons, the Motions are GRANTED.

Facts

Plaintiff, COB Clearinghouse Corporation,[2] filed this Complaint against defendants, Aetna U.S. Healthcare, Inc., Great West Life and Annuity Insurance Company, Blue Cross and Blue Shield of Kansas City and Cigna Corporation (referred to collectively hereafter as defendants). Plaintiff identifies itself as "Authorized Agent for Good Year Tire & Rubber, Bridgestone-Firestone, Babcock & Wilcox, Progressive Processing, First Merit Bank, Cambridge and State Industries." Plaintiff alleges that it represents the interests of these entities pursuant to an "agency contract agreement."

Generally, this lawsuit presents allegations relating to "coordination of benefits" issues arising when two or more health care plans provide benefits to the same individual such as when spouses each maintain insurance through their employers which provides coverage to both. The Complaint alleges the following. Defendants are "third party payers" as defined by Ohio Revised Code (O.R.C.) § 3901.38(A)(8)(a) and "primary plans" as defined in Ohio Administrative Code (O.A.C.) § 3901-1-56(C)(7).

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2. Plaintiff indicates in later briefs that it is "now known by name change as Digital Healthcare, Inc." However, the docket does not show that the Complaint has been amended to alter its caption.

Appendix B

The primary plan provides one or more "benefits contracts" as defined in O.R.C. § 3901.38(A)(2). Good Year Tire & Rubber, Bridgestone-Firestone, Babcock & Wilcox, Progressive Processing, First Merit Bank, Cambridge and State Industries (referred to by plaintiff and hereafter as "the Employers") maintain self-funded employee benefit plans subject to the Employee Retirement Income Security Act (ERISA). The Employers provide a benefits contract for their employees and retirees and their dependents which by operation of the O.A.C. is a "secondary plan" with respect to the beneficiaries. Each of the Employers' secondary plans has made one or more payments to one or more providers (the Complaint does not define provider) on behalf of the employees or beneficiaries. Defendants, as the primary plans, have violated their obligation under the O.R.C. to make timely payment of completed claims and have not reimbursed the Employers or COB for such claims or provided explanation for the rejection of the claims.

The Complaint sets forth five claims. Count One alleges a violation of ERISA. Count Two alleges "federal common law claims." Count Three alleges "unfair and deceptive insurance practices under state law." Count Four alleges bad faith. Count Five alleges unjust enrichment.

This matter is now before the Court upon the Motions to Dismiss filed by defendants Aetna U.S. Healthcare, Inc., Connecticut General Life Insurance Company and Great-West Life and Annuity Insurance Company.[3]

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3. Defendant Aetna moved to dismiss on several grounds. After that matter was fully briefed, defendant Connecticut General Life Insurance Company filed a Motion to Dismiss joining in Aetna's (Cont'd)

Appendix B

Standard of Review

Federal Rule of Civil Procedure 12(b)(1)

A motion under this rule asserts that the court lacks subject matter jurisdiction. In *Madison-Hughes v. Shalala*, 80 F.3d 1121, 1130 (6th Cir. 1996), the court stated:

> When subject matter jurisdiction is challenged under Rule 12(b)(1), the plaintiff has the burden of proving jurisdiction in order to survive the motion. In addition, the district court is empowered to resolve factual disputes when necessary to resolve challenges to subject matter jurisdiction.

(citations omitted).

Federal Rule of Civil Procedure 12(b)(6)

When considering a motion to dismiss plaintiff's complaint pursuant to Rule 12(b)(6) of the Federal Rules of

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(Cont'd)
Motion and asserting no further argument. Defendant Great-West Life and Annuity Insurance Company then fled its Motion to Dismiss incorporating and adopting all arguments set forth by Aetna and providing additional authority for arguments that plaintiff has failed to state claims under ERISA and that plaintiff's state law claims are preempted by that statute. Accordingly, in further discussion below, the Motions will not be addressed separately and Aetna, Connecticut General Life Insurance Company and Great-West Life and Annuity Insurance Company will be collectively referred to as defendants.

Civil Procedure, the allegations of the complaint must be taken as true and construed liberally in favor of plaintiff. *Lawrence v. Chancery Court of Tenn.*, 188 F.3d 687 (6th Cir. 1999). The complaint is only to be dismissed if the plaintiff can prove no set of facts in support of his claim which would entitle him to relief. *Conley v. Gibson*, 355 U.S. 41 (1957), *Hammond v. Baldwin*, 866 F.2d 172 (6th Cir. 1989). However, the complaint must set forth "more than the bare assertion of legal conclusions. *In Re DeLorean Motor Co.*, 991 F.2d 1236, 1240 (6th Cir. 1993); *Scheid v. Fanny Farmer Candy Shops, Inc.*, 859 F.2d 434, 436 (6th Cir. 1988).

Discussion

Plaintiff's ERISA claims are subject to dismissal because plaintiff is not authorized to bring suit under the statute. Section 1132(a) of ERISA specifically provides that only a participant or beneficiary may bring a civil enforcement action. *See also Clarkston v. Hubbard*, No. 95-3287, 1996 WL 382246, **3 (6th Cir. July 3, 1996). This section also authorizes plan fiduciaries and the Secretary of Labor to file suit. 29 U.S.C. § 1132(a)(2). "The Supreme Court has construed [this section] narrowly to permit only the parties enumerated therein to sue directly for relief." *Simon v. Value Behavioral Health, Inc.*, 208 F.3d 1073, 1081 (9th Cir. 2000) (citations omitted).

Plaintiff argues that because the Employers are fiduciaries, they can bring suit and their standing is transferred to plaintiff as their agent. However, while the Employers may be fiduciaries under the ERISA statute, plaintiff cites to no case law supporting its proposition that

it assumes the Employers' right to bring a direct action based on the agency agreements. Plaintiff admits it has no assignee status. *See Ochsner Health Plan v. Northern Louisiana Physician Hospital Organization, Inc.*, No. Civ.A.01-2601, 2002 WL 417260 (E.D.La. March 14, 2002) ("The status of an agent is not the same as that of an assignee who owns the [ERISA] claim.")

Therefore, plaintiff's ERISA claims alleged in Counts One and Two are dismissed. Defendants alternatively argue that these claims fail to state a claim. For the following reasons, the Court agrees.

Count One alleges that defendants have violated the provisions of ERISA "which obligate it to reimburse the Employers for employee and/or employees' dependents medical/health claims made pursuant to an Employers secondary group health insurance plan . . ." (Comp. ¶ 31). However, the Complaint does not identify any specific provision of ERISA which allegedly has been violated. In fact, plaintiff alleges elsewhere in its Complaint that "ERISA does not expressly provide the for [sic] resolution of disputes and conflicts regarding coordination of benefits clauses in both the primary and secondary group health care plans." (*Id.* ¶ 34).

While plaintiff's Complaint cites generally to Sections 1185 through 1191(a) of ERISA, plaintiff's brief does not refer to these sections. Rather, in arguing the standing issues, plaintiff appears to assert that this is a fiduciary's civil enforcement action under Section 1132(a)(3). Even if the Court construes the Complaint as bringing an action under

this Section (and ignores the fact that plaintiff is not an authorized person), money damages are not authorized therein. *Ford v. Uniroyal Pension Plan,* 154 F.3d 613, 617 (6th Cir. 1998) (citing *Mertens v. Hewitt Associates,* 508 U.S. 248,113 S.Ct. 2063, 124 L.Ed.2d 161 (1993)) ("the *[Mertens]* Court disallowed both punitive and compensatory damages under § 1132(a)(3)."). Plaintiff's Complaint seeks tens of millions of dollars. Accordingly, dismissal of Count One is appropriate on this ground as well.

Count Two alleges "federal common law claims." A "federal common law is developed under ERISA only in those instances in which ERISA is silent or ambiguous." *Central States, Southeast and Southwest Areas Pension Fund v. Mahoning Nat. Bank,* 112 F.3d 252, 256-257 (6th Cir. 1997) (citing *Muse v. IBM,* 103 F.3d 490 (6th Cir. 1996)).

Plaintiff alleges that the coordination of benefits rules of the National Association of Insurance Carriers Model Regulations (NAIC) should be adopted and applied here as the federal common law where ERISA does not provide for the resolution of the dispute. Plaintiff relies on *McGurl v. Trucking Employers Welfare Fund,* 124 F.3d 471 (4th Cir. 1997). While it is undisputed that ERISA is silent as to coordination of benefits, *McGurl* states that a federal common law could be created only where the health care plans conflicted. *Id.* at 480-483. Indeed *McGurl* involved a dispute between two plans which had "irreconcilable" coordination of benefits clauses. Each plan denied having primary coverage liability for claimants who were covered under both plans. Plaintiff herein has not alleged a conflict between

plans. Therefore, the Court is not authorized to create a federal common law to address the issue. Count Two fails to state a claim.

Counts Three, Four and Five allege state law claims. Count Three alleges "unfair and deceptive insurance practices under state law," Count Four alleges bad faith and Count Five alleges "quasi contract: unjust enrichment." These claims are all preempted by ERISA.

Congress intended to completely preempt state law and create federal jurisdiction when it enacted ERISA. "It is not the label placed on a state law claim that determines whether it is preempted, but whether in essence such a claim is for the recovery of an ERISA plan benefit." *Peters v. Lincoln Elec. Co.*, __ F.3d __, 2002 WL 432412 (6th Cir. 2002). Plaintiff s state law claims relate to the recovery of ERISA plan benefits and, more specifically, defendants' alleged failure to pay certain benefits. Furthermore, the Sixth Circuit has expressly found state law bad faith claims to be preempted. *Smith v. Provident Bank,* 170 F.3d 609 (6th Cir. 1999). Unjust enrichment claims have also been recognized to be preempted. *See Walbro Corp. v. Amerisure Cos.*, 133 F.3d 961 (6th Cir. 1998) and *Weiner v. Klais & Co., Inc.*, 108 F.3d 86 (6th Cir. 1997). In fact, plaintiff itself alleges in the Complaint, "ERISA preempts Ohio law pertaining to employee rights regarding group healthcare benefits." (Compl. ¶ 33).

For these reasons, defendants' Motions are granted.[4] Furthermore, defendant Blue Cross and Blue Shield of Kansas City is hereby dismissed *sua sponte* for the reasons stated in this Opinion.

Conclusion

For the foregoing reasons, the Motions to Dismiss filed by defendants Aetna U.S. Healthcare, Inc., Connecticut General Life Insurance Company and Great-West Life and Annuity Insurance Company are granted.

IT IS SO ORDERED.

s/ Patricia A. Gaughan
PATRICIA A. GAUGHAN
United States District Judge

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4. Because dismissal is appropriate on these grounds, the Court need not address defendants' argument that the agency contracts are void due to Patrick Lawlor's conviction.